PHYSICIAN'S CERTIFICATION FOR NURSING FACILITY AND MI/MR SCREENING

TO BE COMPLETED BY A PHYSICIAN PRIOR TO ADMISSION TO A MEDICAID CERTIFIED NURSING FACILITY. (TYPE OR PRINT LEGIBLY IN INK)

(I) FACILITY NAME | **(2) FACILITY PROVIDER#**

(3) NAME OF INDIVIDUAL | **(4) DOB** | **(5)** ☐ **MALE** ☐ **FEMALE** | **(6) MEDICAID #**

(7) INDIVIDUAL'S STREET ADDRESS | **(8) PHONE #** | **(9) SS #**

(10) CITY | **(11) COUNTY** | **(12) STATE** | **(13)ZIP CODE** | **(14) MEDICARE#**

(15) INDIVIDUAL LIVES: ☐ **ALONE** ☐ **WITH SPOUSE** ☐ **WITH FAMILY** ☐ **OTHER** *(SPECIFY)* _____

(16) INDIVIDUAL PRESENTLY AT: ☐ **HOME** ☐ **HOSPITAL** ☐ **NURSING FACILITY**

(17) NEXT OF KIN OR CAREGIVER

(18) CAREGIVER'S ADDRESS *(IF DIFFERENT FROM INDIVIDUALS)*

PHONE NUMBER

(19) ADMITTING DIAGNOSIS:

Primary _____

Secondary _____

Significant Problem(s) _____

(20) BEHAVIOR: *Check appropriate box.*

☐ ANXIOUS ☐ DEPRESSED ☐ HOSTILE
☐ AGITATED ☐ WANDERS ☐ LETHARGIC
☐ CONFUSED ☐ DISORIENTED ☐ HALLUCINATES
☐ DELUSIONS (Person, time, place)

(22) SENSORY: *Check appropriate box.*

☐ HEARING IMPAIRED ☐ COMATOSE
☐ VISION IMPAIRED ☐ PARALYSIS
☐ CANNOT COMMUNICATE

(21) ACTIVITIES OF DAILY LIVING: *Check appropriate box.*

Eating	Independent ☐	Assist. Required ☐	Total Dependence ☐
Toileting	Independent ☐	Assist. Required ☐	Total Dependence ☐
Bathing	Independent ☐	Assist. Required ☐	Total Dependence ☐
Personal Hygiene	Independent ☐	Assist. Required ☐	Total Dependence ☐
Ambulation	Independent ☐	Assist. Required ☐	Total Dependence ☐
Transferring	Independent ☐	Assist. Required ☐	Total Dependence ☐
Dressing ☐	Independent ☐	Assist. Required ☐	Total Dependence ☐

Preadmission Screening and Resident Review (PASRR) Level 1.

Complete in order to determine if a Level II is required. *Mark yes or no to the questions below.*

(23) Does this individual have a diagnosis of mental retardation? YES ☐ NO ☐
If answered yes, this individual needs referral for a Level II MR evaluation.

(24) Does this individual have a history of or present any evidence of cognitive or behavior functions that indicate the need for an MR evaluation? YES ☐ NO ☐
If answered yes, this individual needs referral for a level II MR evaluation.

(25) Does this individual have a diagnosis of a serious and persistent mental illness? (Diagnosable under DSM IV) YES ☐ NO ☐
If answered yes, this individual needs referral for a Level II MI evaluation.

(26) Does this individual take, or have a history of taking, a psychotropic medication on a regular basis for a mental illness? YES ☐ NO ☐
If answered yes, this individual needs referral for a Level II MI evaluation.
List medication name, dosage, frequency, and date ordered:

DO NOT REFER FOR A LEVEL II MI EVALUATION IF THE PRIMARY DIAGNOSIS IS DEMENTIA OR ALZHEIMER'S.

☐ I certify this individual has no mental illness or retardation, is not a danger to self or others, and is appropriate for nursing facility placement.

☐ This individual has an indication of mental illness or mental retardation and is being referred for a Level II Screening.

☐ I certify this individual has a mental illness or mental retardation but is not a danger to self or others. However, this individual has a medical condition which would impede their potential to benefit from specialized services. This individual is appropriate for nursing facility placement.

Signature of Physician: **Date:**

Print or Type Name: **Telephone#**

Address:

White copy - Medicaid Regional Office Yellow copy - Nursing Facility Pink copy - Physician

Instructions for Completing Physician's Certification
(DOM 260-NF)

Item 1: Complete facility name.

Item 2: Complete facility provider number.

Item 3: Complete individual's name **exactly** as it appears on his/her Medicaid card.

Item 4: Complete individual's date of birth.

Item 5: Check appropriate box.

Item 6: Complete individual's Medicaid number **exactly** as it appears on his/her Medicaid card.

Item 7,10, 12, 13: Complete individual's full mailing address.

Item 8: Complete individual's phone number.

Item 9: Complete individual's social security number **exactly** as it appears on his/her Social Security card.

Item 11: Complete county in which individual lives.

Item 14: Complete individual's Medicare number **exactly** as if appears on his/her Medicare card.
(NA section if client is not presently receiving any Medicare coverage)

Item 15, 16: Check the appropriate box.

Item 17, 18: Complete Next of Kin or Caregiver name, full mailing address and phone number.

Item 19: Complete all Diagnosis and any significant problems.**(DO NOT USE ICD-9 CODES)**

Item 20, 22: Check all appropriate boxes.

Item 21: Check appropriate box to indicate individual's functional ability with Activities of Daily Living.

Item 23-26: Mark yes or no to all questions. **Note instructions to any questions answered yes.**

Must have complete signature of Physician, date signed and Physician's full mailing address.

FAX A LEGIBLE COPY OF THE DOM 260 NF TO THE STATE OFFICE DIVISION OF MEDICAID
(601) 359-1383